



MEDICAL RELEASE AND CONSENT AGREEMENT

For consideration of my acceptance to participate in programs and activities at hunger education and resource training (h.e.a.r.t.), I do hereby for myself, my heirs, executors, and administrator, waive, release and forever discharge any and all rights and claims for damages which I may have or which may hereafter accrue to me against the h.e.a.r.t., their members, respective directors, officers, agents, representatives, successors, staff, faculty, and/or assigns, individually or collectively for any and all damages and liabilities which may be sustained and suffered by me in connection with my association with/or arising out of my traveling to, participation in, and returning from any activity sponsored by hunger education and resource training (h.e.a.r.t.).

The patient and others whose signatures are attached below do hereby consent to any and all medical, preventative medicine and surgical treatments including anesthesia and operations, which may be deemed advisable by his or her physician and surgeons. The intention hereof being to grant authority to administer and to perform all and singularly any examinations, treatments, anesthetics, preventative treatment, operations and diagnostic procedures which may now or during the course of the patient's care be deemed advisable or necessary.

In witness of our consent and agreement to the matters stated in the preceding sentences, we have subscribed our signatures below. This document is to remain in effect for one year from the date it is signed by the parent or legal guardian or until revoked in writing.

Participant's Name _____
 (Please print) Last First Middle

Address _____
 Street City State Zip

Phone number (_____)_____

List any health issues or allergies: _____

*Name of Primary Insurance Carrier _____

Policy # _____ Insurance Co. phone # (_____)_____

Person to contact in case of emergency _____

Phone # (_____) _____ 2nd Phone # (_____)_____

Participant's Signature _____ Date Signed _____

Signature of Parent or Guardian _____ Date Signed _____

Please circle: father mother legal guardian

***Please include a copy of your insurance card to be made part of the file.**